

Robert S. Cutler, D.O.
Proctologist, Board Certified

Medical and Surgical Treatment
of Colon and Rectal Disorders
Colorectal Cancer Screening
Specializing in "Painless" Hemorrhoid Treatments and Prevention of Colon Cancer

Patient's Name:

Procedure: Colonoscopy

Surgery Center: North County (561) 626-6446

ARRIVE AT FACILITY ON _____ **NO LATER THAN** _____ **AM PM (ESTIMATED TIME)**
(1-1/2 hr before procedure) The surgery center will confirm your exact time of arrival.

** Please complete the enclosed information for the facility and bring with you for your appointment.

PREPARATION:

The PREPARATION IS KEY to a successful procedure, so please follow the enclosed instructions.

**Prior to your preparation you are REQUIRED to advise if you have any of the following:
abnormal lab values, kidney/renal disorders or heart problems.**

If **Bloodwork** is ordered it must be completed 5 days prior to procedure (but not more than 30 days prior.)

Transportation is required to and from the facility.

You will not be able to drive for 12 hours after the procedure.

If you are taking weight loss medications, Vitamin E, Aspirin, NSAIDS (anti inflammatory), Ibuprofen, or Advil, please notify the nurse prior to the procedure. Medications such as these can cause serious complications including excessive bleeding during the procedure, you must **stop taking these medications at least 8 days prior to your procedure.** If you are using any other medications including insulin, please discuss these with the anesthesiologist at the surgery center at least 3 days prior to the procedure.

Do NOT eat or drink anything after MIDNIGHT. If you wear contact lens, please do not wear them on the day of the procedure. Do not wear nail polish.

PAYMENT:

Please note the physician's fees are separate from the surgery center, the anesthesiologist, and the pathologist. If payment is not received, the procedure will be cancelled until other arrangements can be made.

A great deal of time and effort is invested in scheduling this procedure for you. Should you cancel within 72 hours of the procedure, you will be responsible for a \$50.00 cancellation fee.

Your estimated deductible of \$_____ and / or co payment of \$_____ **must be received 14 days prior to the procedure.** Please be advised if your insurance company has not paid your account in 45 days, the balance will become your responsibility.

By signing below, I have read, understand and agree to the terms above, the attached the FDA Alert and preparation.

Patient's Signature _____ Date _____

Should you have any further questions, please do not hesitate to contact the office immediately.

Please send all PAYMENTS to **Relief Center: PO Box 211465 Royal Palm Beach, FL 33421-1465**

13005 Southern Boulevard, Suite 121, Loxahatchee, FL 33470 (561)842-5050
538 Port St Lucie Boulevard, Port St Lucie, FL 34984 (772)871-6222
Fax: (561) 793-9989